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ABSTRACT

Three separate reports are included in this document on American Indian alcoholism. Section I of the document (December 1969) outlines the history, nature, extent, and significance of Indian alcoholism (reporting that the incidence of alcoholism among Indians is twice that of the national average, low socioeconomic status, rather than a physiological propensity, is cited as a major cause). Section II (February 1970) addresses the problems of alcoholism prevention, control, and treatment (direct personal services via both professionals outside the community and nonprofessionals within the community; thorough, coordinated training for those providing services to alcoholics and/or their families; major health education principles and methods; community relationships which utilize the Indian Health Service as a catalyst for program development; the importance of data collection, research, and evaluation in any alcoholism program; and a suggested approach to program planning, including 12 specific recommendations). Section III (April 1970) is a reference guide to alcoholism programs and resources (includes a glossary of common words used in literature on alcoholism, short descriptions of a few of the modern methods of alcoholism treatment, and a list of organizations and agencies which can provide information, consultation, and, in some cases, financial support for community alcoholism program development). (JC)

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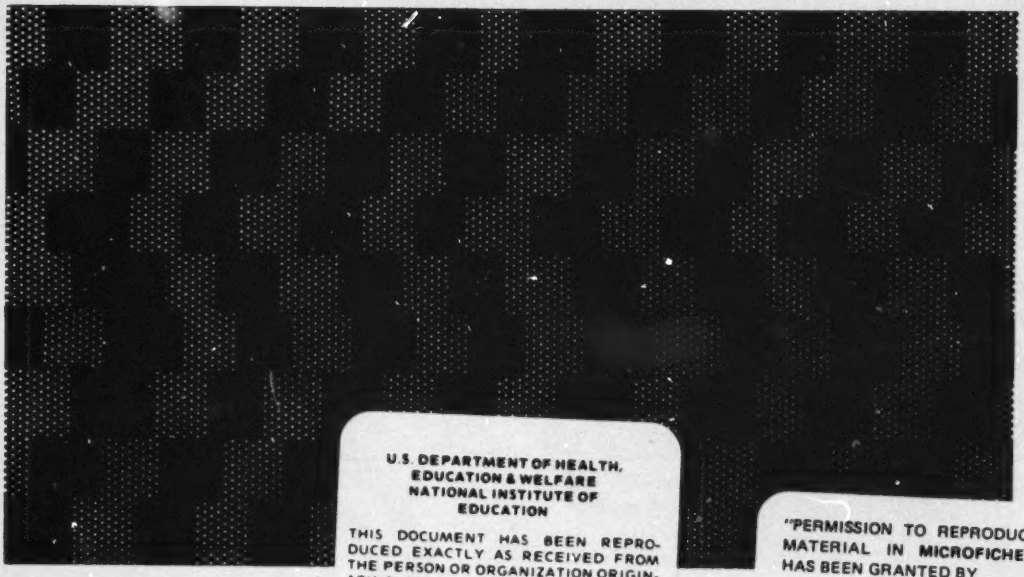
a high priority health problem



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a report of the

Indian Health Service Task Force on Alcoholism

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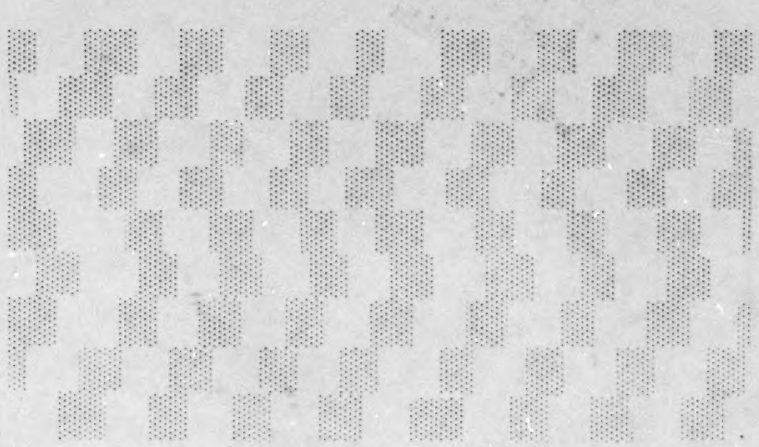

a report of the

Indian Health Service Task Force on Alcoholism

DHEW Publication No. (HSA) 77-1001

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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FOREWORD

Alcohol is the most abused drug in the United States. As indicated in the First Special Report to the U.S. Congress on Alcohol and Health from Secretaries of Health, Education and Welfare, 1971, the extent of problems related to alcohol abuse and alcoholism has reached major proportions. Among American Indians (including Alaska Natives), the incidence of alcoholism is estimated to be at least two times the national average.

In October 1968, the Indian Health Service Task Force was appointed to review the extent of alcoholism on Indian reservations and communities, evaluate existing programs and resources, and provide guidelines and plans of action to assist in meeting the problem. Task Force members were:

George Bock, M.D., Director, Navajo Area Indian Health Service–Chairman,
Robert Fortuine, M.D., Assistant to the Chief, Office of Program Services, IHS–Executive Secretary.
Robert Bergman, M.D., Psychiatrist, Navajo Area.
John Bopp, Social Worker, Ft. Hall Service Unit.
Joseph Exendine, Tribal Affairs Officer, Aberdeen Area.
Robert LaFromboise, Health Educator, Flathead Service Unit.
Eileen Maynard, Anthropologist, Pine Ridge Service Unit.
Sheldon Miller, M.D., Psychiatrist, Navajo Area.
Ben Prins, M.D., Medical Officer in Charge, Indian Health Center, Dulce, New Mexico.
Sylvia P. Rhodes, PHN Supervisor, Santa Fe Service Unit.

Section 1 of the Task Force Report (December 1969), outlines the history, nature, extent and significance of alcoholism in the Indian population.

Section 2 (February 1970) is addressed to the problems of prevention, control and treatment of alcoholism.

Section 3 of the Report (April 1970) is a reference guide to alcoholism programs and resources.

Additional program information for the prevention and control of alcohol abuse and alcoholism is available from the National Institute of Alcohol Abuse and Alcoholism (NIAAA), which was established by Public Law 91-616, the "Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970."

Emery A. Johnson, M.D.
Assistant Surgeon General
Director, Indian Health Service

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Section I–Summary of Background Information for Development of Specific Plans of Action in Dealing With Alcoholism (December 1969)

INTRODUCTION AND DEFINITION OF THE PROBLEM

The Indian Health Service considers alcoholism to be one of the most significant and urgent health problems facing the Indian and Alaska Native people today. Probably no other condition adversely affects so many aspects of Indian life in the United States. It is the policy of the Indian Health Service that services and programs for the prevention and comprehensive treatment of alcoholism be given the highest possible priority at all levels of administration.

Alcoholism is an exceedingly serious problem everywhere in the Nation, but virtually nowhere is it getting the attention that it deserves from health workers, not to mention other professionals and community leaders. Its roots are many and complex. It is called a disease by some, a symptom by others, and apparently is totally ignored by a substantial number. Parts of the problem are in the domain of many different professional and non-professional groups, yet leadership and the full cooperation and participation of all are essential for its effective control. Although health workers have a part to play, perhaps a leading part, alcoholism is no less the responsibility of the clergy, teachers, law enforcement officers, courts, welfare agents, social workers and perhaps, most of all, the community itself. Alcoholism is harmful not only to the physical and mental health of individuals, but to family relationships, economic functioning and the whole fabric of society. It is a problem that demands attack on many fronts.

Alcoholism in the Indian population has certain features which make it a particularly serious problem. This report will attempt to delineate some of the origins, causes, and characteristics of the problem in the hope that a clearer understanding of the unique aspects of Indian alcoholism will help health professionals to give it the priority it needs and to deal with it more effectively on a local level. Indian leaders more and more are recognizing the gravity of the alcohol problem and usually are agreeable to assisting in every way.

The Indian Health Service has defined alcoholism as follows:[20]

> "A disease, or disorder of behavior, characterized by repeated drinking of alcoholic beverages, which interfers with the drinker's health, interpersonal relations or economic functioning."

This definition, modified and condensed from that of the World Health Organization,[42] encompasses the total range from alcohol dependence through what is generally called problem drinking to repeated simple intoxication, *provided* that health, family, and other social relations and/or economic functioning are impaired as a consequence.

It is important to recognize that alcoholism may be considered a disease, in the strict sense, *or* a behavioral disorder. The term alcoholic is commonly applied to patients suffering from alcohol addiction, Laennec's cirrhosis, delirium tremens and certain other recognized disease syndromes associated with the excessive use of alcohol. However, the regular Saturday night drinker who drings to intoxication, then severely injures himself or others while driving home, is less definitely an "alcoholic" in most people's minds, yet he is every bit as serious a health threat to himself, and what is worse, a threat to the health of others. Both types of alcoholism must be accommodated in the definition and both types must ultimately be dealt with by the Indian Health Service and the community.

Alcoholism by the above definition is a costly proposition in every sense of the word. Personal health may be impaired by cirrhosis and its complications, neuropsychiatric disorders and nutritional deficiencies. The majority of accidents, especially the fatal ones, are associated with alcohol as are nearly all homicides, assaults, suicides and suicide attempts among Indians. The vast majority of all arrests, fines and prison sentences in the Indian population are related to alcohol. The loss of personal freedom and productivity, the break-up of families, the hardship and humiliation involved are considerable, although not easily measured.

A substantial portion of medical care, welfare and law enforcement agency costs must be attributed directly or indirectly to the effects of excessive drinking. In communities with few enough resources already, such a diversion of funds is particularly unfortunate.

A great deal of misinformation is abroad concerning the subject of Indians and alcohol. Indeed, the "drunken Indian" is one of the most persistent and pernicious stereotypes found in American folk culture today. The attitude that Indians somehow have an inherent inability to cope with alcohol is quite prevalent among a great many people, including health professionals, clergy, teachers, social workers and police officers, as well as bartenders and simply private citizens. There are differences, indeed, in the patterns of alcohol use by some Indians, just as there are differences among Jews, Englishmen, Irishmen,

and Italians in the manner in which they drink. Such differences include variations in attitudes toward drinking and drunkenness, in responses to deviant drinking behavior, in the ways in which young people are introduced to alcohol, and the way in which the social group acts towards excessive or harmful drinking. These patterns of behavior for any cultural group often have a reasonable historical, social, or economic basis. No valid evidence is available that Indians differ in any way from others in their physiological or constitutional response to alcohol.

HISTORICAL BACKGROUND

Most authorities agree that none of the Indians north of Mexico knew distilled alcoholic drinks prior to the arrival of the Europeans in the 16th and 17th century, although there is evidence that some tribes made fermented beers or wine, which were usually employed only in ceremonies and religious rituals.[15, 22, 37, 41]

The Indians, Eskimos and Aleuts of North America were therefore quite unprepared to deal with the distilled beverages the early explorers and traders commonly offered them as a sign of friendship.[41] It is not surprising that some declined to drink, some spat it out in disgust and others accepted it and drank to the point of intoxication. Alcohol was credited with supernatural powers among certain tribes in the 16th, 17th and 18th centuries[8] because it released inhibitions, dulled pain and at the extreme, induced oblivion—the same reasons many people find alcohol helpful today.

Alcoholic beverages soon became common along the entire frontier. The French, English, Dutch and Spanish all used it as an enticement to alliance or as an article of trade. In the northern and eastern forests, whiskey played a dominant part in the early activities of the fur-traders, being used chiefly as a reward on special occasions such as the end of a successful season of trapping.

Most of the respectable traders discouraged the use of alcohol as regular payment for furs partly because drinking obviously lowered productivity but partly also because they could see all too clearly how disruptive it could be in a society with no traditional means of coping with it.[41]

As competition for furs increased, however, some traders were led to use alcohol as an extra inducement to the Indians. Before long the whiskey trade became something of an end in itself, since the more unscrupulous traders found that the desire for strong drink led some Indians to give up their most valuable possessions. The exploitation which inevitably resulted from such activity is clearly described by Hiram M. Chittenden:

> "It (the liquor) was retailed with the most systematic fraud, often amounting to a sheer exchange of nothing for the goods of the Indians. It was the policy of the shrewd trader first to get his victim so intoxicated that he could no longer drive a good bargain. The Indian, becoming more and more greedy for liquor, would yield up all he possessed for an additional cup or two."[40]

The drink was usually a cheap form of brandy, rum or whiskey, not only diluted but often adulterated with drugs, such as laudanum. Some justified the added opiate on the "humane" grounds that it would diminish the likelihood of destructive aggression while the Indians were drunk.[18]

Indeed, aggressive acts appeared to be a common outcome of heavy drinking bouts. A number of early writers noted the terrible effects which strong liquor had on an Indian community. The general pattern consisted of rapid drinking by the men until utter drunkenness ensued or until the supply of alcohol was exhausted. Verbal abuse of one another then occurred followed by fist fights and finally armed violence.[6, 17, 22] During such episodes, women usually tried to stay clear of the men, often gathering up all the weapons they could find and hiding them along with their children in the woods until the effects of the liquor had worn off and it was safe to return. They might come back to find the camp a shambles, with some men dead, some maimed and the rest asleep.[22] Of course this behavior was not characteristic of all Indian communities, nor of all individuals, even in the eastern forests, but the general pattern was apparently widespread.

Most tribes had no traditional way of coping with such a problem. There was no system for punishing crimes committed while a man was drunk, no matter how terrible, since the drunken man was not considered in control of his actions.[3,30] This uncertainty regarding how the community should react to drunkenness is a key historical point which is relevant to contemporary attitudes.

Defeats in war, forced relocation of tribes far from their traditional homes, the extermination of the buffalo and other game, the breakup of families, and constant harassment from settlers and soldiers all contributed to the demoralization of these proud independent people. In some areas hunters were forcibly turned into farmers, an activity which was humiliating and wholly distasteful to them. In other areas the poor reservation land permitted no useful activity at all and the Indians were forced to live on the Indian Agent's dole. Wherever there were Indians however, there usually were unscrupulous bootleggers who were willing to help them forget their troubles, if only briefly, at the price of their few remaining possessions.

In the Far North, where hunting still was a way of life and there were neither soldiers nor reservations, the whalers and others found a ready market for liquor. Here too disaster in form of starvation was sometimes the result, since a whole fishing or hunting season might be dissipated in drunkenness.

As early as the 17th century, thoughtful Indian leaders recognized the real and potential gravity of the alcohol problem. Many requested the traders and others not to permit liquor to be sold to their people, though usually their efforts were in vain.[40] Because of the mounting seriousness of the alcohol problem during the 18th and 19th centuries, several Indian religious prophets, notably the Seneca, Handsome Lake and the Pauite, Wewoka, advocated a return to the old ways, including total abstention from alcohol.

The contemporary Native American Church advocates some of the same principles.

An Indian Chief, Little Turtle, appealed directly to President Thomas Jefferson in January 1802. Among other things, he pointed out that Indians were an industrious people kept poor by liquor and that they had become less numerous and less happy since the introduction of this "fatal poison." Partly in response to Little Turtle's request for the prohibition of liquor sales to Indians, President Jefferson, less than a month later, called upon Congress to take steps to control the liquor traffic. "These people," he pointed out, "are becoming very sensible of the baneful effects produced on their morale, their health, and existence, by the abuse of ardent spirits: and some of them earnestly desire a prohibition of that article from being carried among them." Congress acted promptly, authorizing the President "to prevent or restrain the vending or distributing of spirituous liquor among all or any of the said Indian Tribes . . ."[7]

Thirty years later, on July 9, 1832, Congress passed the first general statutory prohibition on liquor traffic, based on the constitutional authority of Congress to regulate commerce with the Indian Tribes. The law, as expanded over the years, covered sale, gift, transportation and possession of liquor on reservations or sometimes adjoining Indian land, without regard to State boundaries. Later ale, beer and wine were added to the list of prohibited drinks. Other restrictions on liquor traffic were incorporated into individual treaties and agreements with different tribes.

These laws were originally designed mainly to protect the Indians from cruel exploitation by the unsavory whiskey traders. Both the Government and the tribal leaders recognized the need for such control, though undoubtedly from somewhat different points of view. Enforcement of these laws was never markedly successful, however, since bootlegging and smuggling could hardly be effectively controlled in the vast, thinly populated Indian country by the few enforcement officers available for such duty. There is even some evidence that certain Government officials issued spirits to the Indians as part of their regular rations.[15]

By the 20th century, the Indian liquor laws were increasingly recognized, especially by the Indians themselves, as being frankly discriminatory. Although Indians had become full citizens under the law in 1924, they alone were not permitted to buy drink legally after Prohibition was repealed in 1933. The bootleggers, as before, continued to flourish. Not only did the Indians have to pay far more for their drinks than others, they also had to drink covertly to avoid being arrested, imprisoned or fined. The very illegality of drinking may in fact have increased its appeal, especially for the adolescents and young adults.

Many Indians felt increasing humiliation and resentment against the Government for this unequal treatment before the law. Finally, as a result of many pressures, Congress repealed the Federal Indian liquor laws in August 1953, leaving the question to the individual States for off-reservation communities and to Tribal Councils for reservation lands. A number of reservations still retain local restrictive laws of their own, some forbidding liquor entirely and others controlling or monopolizing its sale and distribution.

ALCOHOL AND THE INDIAN TODAY

General Comments

This section will attempt to describe some of the general patterns of drinking in the Indian population and then outline the extent to which excessive drinking has adversely affected health, social and economic well-being.

The sources of information on alcohol usage are numerous but of unequal quality and usefulness. Vital statistics, hospital records, court records, social service and welfare records, traffic accident reports and liquor sales are examples of records which can be and have been used for the determination of the extent and patterns of alcohol use and abuse. No single agency collects information on all aspects of the problem among Indians however, nor does any one agency have access to all sources of information which may be available.

Measurement of the patterns of drinking and the extent of alcoholism in any population is difficult, even under the most favorable circumstances. The difficulties are greatly compounded when dealing with the Indian population, however, because of the scarcity of careful studies and the widespread misconceptions and bias which surround the subject of Indians and alcohol.

Most people will agree that alcoholism is a major problem among Indians but will disagree on its nature and size. Unfortunately, those with the closest contact with Indians are often the least scientific in their judgments, while those who set up a rigorous study design occasionally have insufficient knowledge of Indians and their ways. Adding to the confusion are differing definitions of the problem, different goals in the collection of data and perhaps most importantly, differing patterns of drinking in the various Indian groups. The North American Indians are a heterogeneous population with a great diversity of cultures, attitudes and religious persuasions.

It is necessary, therefore, to be cautious in the interpretation of the data which follow. In general, reasonably valid information is presented for a specific place and for a specific time. All the figures have problems of reliability or validity and none should be the basis for generalization to the Indian population at large. They are intended rather, to give a general view of the extent of the problem and its many manifestations.

The Patterns and Extent of Indian Drinking

In one central plains reservation, 70 percent of the population over 15 reported that they drank. This number included 82 percent of the men and 55 percent of the women. In the age group 20-29, 99 percent of the men and 72 percent of the women were drinkers, whereas in the age group 30-39, the

figures were 93 percent and 85 percent respectively. After forty there was a marked decline in the percentage of women drinking and a smaller decline for the men.

In the 15-17 age groups, 50 percent reported drinking, - 60 percent of the boys and 40 percent of the girls. Drinking began between the ages of 9 and 17, with an average of 15½. Of those under 17, 88 percent reported that most of their friends drank. In this study, 31 percent of the total sample were abstainers, 45 percent drank less often than 3 times a week and 24 percent drank three or more times a week. Evidence was presented to show that both sexes, but especially the women, were drinking more in this generation than in the last.[38]

In a small Great Lakes Indian community, only seven out of 74 persons over 18 could be classified as non-drinkers or moderate drinkers. Most youths began drinking between the ages of 14-16.[13]

In a study of high school students in a Plains Tribe, 84 percent of the boys and 76 percent of the girls claimed they drank. Thirty-seven percent claimed they drank frequently.[29]

Among Southwestern Indians hospitalized for various reasons, 78 percent of men and 48 percent of women described themselves as drinkers. Two thirds of these men and one half of the women considered themselves "heavy drinkers." The percentage of drinkers varied in different tribes from 73 percent to 86 percent in the men, and from 20 percent to 68 percent in the women.[34]

In a study of an Indian village in the Southwest prior to repeal of the liquor laws, 105 out of 614 adults were observed to be regular drinkers and about half were estimated to be at least occasional drinkers. The male to female ratio was 3 to 1. After repeal the pattern did not change noticeably.[15]

Although it is unsafe to generalize, what few studies that have been done on drinking patterns in Indians have a certain consistency. Drinking is widespread, reaching its peak of frequency in the age groups 25-44. Males usually outnumber females by a ratio of at least 3 to 1. By the age of 15, most youths of both sexes have tried alcohol and some are drinking regularly. After the age of 40, there is noticeable decline in the number of drinkers and the extent of drinking. Many Indians of all ages are total abstainers.

For the most part drinking occurs in peer groups or extended family groups. Alcoholic beverages, most often beer and wine, are freely shared within the group. Drinking usually is associated with happy or festive occasions, such as weekend social events, pay-day, pow-wows, or the end of a work season. Intoxication is a common but by no means inevitable outcome of these episodes.

Alcoholism and its Effects

The adverse effects of excessive alcohol use may be approached through an examination of general mortality and hospitalization statistics, special studies, and welfare, court and police records.

In calendar year 1967, there were 183 Indian deaths primarily attributed to alcoholism, alcoholic psychosis, or cirrhosis with alcoholism in the 24 Federal reservation States, for an overall mortality rate of 33.1/100,000. These deaths made up 3.8 percent of all Indian and Alaska Native deaths that year. A substantial but unknown percentage of the 1,000 other Indian deaths from accidents were due directly or indirectly to the problem of excessive drinking.[21]

In a Lower Plateau tribe, there were 56 deaths directly associated with drinking and 5 others indirectly associated with drinking in a population of 1,581 in an 11 year period. Of the 61 deaths, 47 were males and 14 were females. The cause of death included: 12 suicides, 12 "over-consumption of alcohol," 11 auto accidents, 8 other accidents, 6 murders and 12 miscellaneous.[35] On the same reservation, the Service Unit Director states that 38 percent of all hospital days for 1967 were attributed to the use of alchol.

In a northern plains community of 3,500 there have been 42 deaths attributed to excessive drinking in a 4 year period. Ten of these were homicides and another six were suicides.[19]

A study of adult Indian autopsies in the Southwest showed an incidence of fatty, nutritional cirrhosis of 12.8 percent, about four times the national average. This condition may be related, though not necessarily, to excessive drinking.[31]

In an Indian community of 2,300 persons in the northwest, a register of accidents and their relation to drinking was kept in fiscal year 1968. Forty-five out of 56 auto accident injuries, 56 out of 181 other accidental injuries, 30 out of 32 fights involving injury and all 35 suicide attempts were related to drinking. These figures were felt by the IHS staff to be conservative.[5] In a study of suicide in a southwestern Indian tribe, 47 percent of cases involved intoxication at the time of or just before the act.[26]

Since deaths must ultimately be assigned to a single cause only many a victim of chronic alcoholism or acute intoxication is listed as a death from accident, suicide, homicide, bronchopneumonia or a host of other causes. Hospitalization data have many of the same limitations, especially if only the primary or immediate cause of hospitalization is considered. Many hospitals, in fact, will not admit a patient suffering from the effects of alcohol unless there is another justification for admission as well. Diagnostic fashions are another source of confusion in this area. Hospitalization rates will be affected by the beds available, local hospital policy, recognition of the relative importance of alcoholism as a health problem and the attitudes of the local people toward their hospital.

For the period July 1, 1967 through June 30, 1968, there were 1,415 discharges from all Indian Health Service and contract hospitals with the primary diagnosis of simple alcohol intoxication and another 1,372 discharges for the various other forms of alcoholism. These totals account for 1.7 percent and 1.6 percent, respectively, of the total discharges from these hospitals. For the Indian Health Service Hospitals in the Window Rock, Phoenix, Aberdeen and Billings Areas in the period July 1, 1968 through

December 31, 1968, when more detailed information was available, simple intoxication was listed as *one* diagnosis on 3.2 percent of all discharges and other forms of alcoholism on another 1.3 percent. For males aged 20-44, where the problem of alcoholism is primarily concentrated, these figures become 12.4 percent and 5.0 percent respectively. The overall sex ratio (M/F) for discharges for which simple intoxication was listed was 2.51/1.00. For cirrhosis with alcoholism the sex ratio was 0.87/1.00 and for delirium tremens it was 5.63/1.00.

An overall view of the age and sex distribution patterns for simple intoxication and cirrhosis is best shown by a table of discharge rates, which are derived from primary discharges from all IHS and contract hospitals for fiscal year 1968.

TABLE I–Discharge Rates (per thousand population) for Simple Intoxication & Cirrhosis with Alcoholism, all IHS and Contract Hospitals, July 1, 1967 through June 30, 1968

Age	Simple Intoxication			Cirrhosis with Alcoholism		
	M	F	Total	M	F	Total
0-14	0.2	0.0*	0.1	-	-	-
15-19	2.4	0.9	1.6	-	-	-
20-24	8.3	2.8	5.5	0.0*	0.0*	0.0*
25-34	13.7	5.5	9.5	1.4	2.6	2.0
35-44	17.2	7.0	12.1	2.9	3.6	3.2
45-54	10.0	3.9	7.1	2.4	2.6	2.5
55-64	6.3	1.7	4.1	1.8	1.7	1.8
65 +	2.8	1.0	2.0	0.5	0.2	0.4
All ages	5.1	2.0	3.5	0.7	0.9	0.8

This table clearly shows for both sexes the gradual increase in rates with age, a peaking in the age group 35-44 and a gradual decline thereafter. The sex ratio for simple intoxication remains fairly constant with age at an average of 2.55/1.00, whereas for cirrhosis with alcoholism the overall sex ratio is reversed at 0.78/1.00.[21]

*numbers too small for calculation of a reliable rate.

The records of the local police, courts and prisons provide one of the most useful and graphic sources of information on the extent and impact of alchol problems in a population. In many Indian communities, it is often the only source which has been explored. In interpreting such information, however, a word of caution is necessary. Police and courts, whether Tribal, municipal, county, State or Federal, are inclined to deal more harshly with Indians who are found intoxicated than they would with non-Indians. An Indian usually runs a far greater risk of being arrested and locked up for drunkenness than a non-Indian would under similar circumstances. Arrest and conviction figures for Indians, therefore, are somewhat inflated when compared with those of the general population. Even when these allowances are made, however, the figures are still an impressive testimony not only to the extent of drinking but to the social and family disruption, the loss of productiveness, the loss of self-respect, and the accidents and ill health caused by the excessive use of alcohol.

The figures that follow are chosen to be fairly representative of a considerable mass of available information.

In 1960, Indians were arrested 12.2 times as frequently for alcohol-related offenses as the U.S. population generally. Whereas 43 percent of all arrests in the U. S. were related to drinking, the comparable figure for Indians was 76 percent. Drunkenness *alone* accounted for 71 percent of all Indian arrests. The arrest rate for non-alcohol related offenses was found to be only slightly above the U. S. average.[36]

In a central plains reservation, there were in one year 2585 arrests for "disorderly conduct with drunkenness" in a population of 4600 adults. Over a three year period, 44 percent of males and 21 percent of females had been arrested at least once for a drinking-connected offense. Of these, 2/3 had been arrested more than once and 1/10 more than 10 times. Of all juvenile offenders (under 18) one-quarter had been booked at least once for disorderly conduct or a drunken driving charge. Thirteen percent of the entire population aged 15-17 had been booked at least once on a charge related to drinking.[29]

In the Southwest, a reservation reported that 70 percent of crimes on the reservation were alcohol-related. In an off-reservation town nearby there were 750 arrests per month for drunkenness, 90 percent of which were Indians.[11]

In one State Penitentiary, Indians made up 34 percent of the inmates whereas in the State they comprised only 5 percent of the population. A large majority of the crimes were committed while under the influence of alcohol.[36] In 1959, all 36 Indian prisoners at a Federal prison had been convicted of murder or manslaughter which had occurred while the individual was intoxicated.[2]

On a northern plains reservation with a total population of 3500, there were in fiscal year 1968, 1769 arrests resulting from excessive drinking, 10 percent of them in juveniles.[19] Further in the northwest, there were 445 disorderly conduct arrests and 72 liquor possession arrests in one year in a population of 2300. Male adults outnumbered both female adults and juveniles by a ratio of about 5:1.5

The excessive use of alcohol clearly has a tremendous impact not only on the lives of individual Indians and their families, but on the tangible and intangible resources of their communities. Nearly every person, whether a drinker or not, is touched in some way by alcoholism. A poignant example comes from a reservation where a recent survey of high school students showed that no less than 339 out of 350 persons disliked living in their own community because of excessive drinking![1]

FACTORS CONTRIBUTING TO ALCOHOLISM IN INDIANS

General Comments

To devise effective measures for the prevention and control of alcoholism requires some understanding of the roots and causes of the various

manifestations of harmful drinking in the Indian population. It is inevitable that any discussion of contributing factors will be an oversimplification of what is an exceedingly complex problem with many ramifications in different tribes, communities and individuals. Recognizing these limitations however, it may still be useful to make some comments which have some general acceptance among many qualified persons, including Indian leaders themselves.

These comments will be set forth under two broad headings: historical-cultural factors and social-psychological factors.

Historical-cultural factors

As pointed out above, alcoholic beverages are a fairly recent addition to the experience of the American Indian people. Until the coming of the Europeans, Indians had very little or no contact with alcoholic beverages, and therefore had no cultural means of dealing with them in their everyday life. In contrast, western culture has for thousands of years, used alcohol for social, religious and therapeutic purposes. There has in short been more time in western culture to establish the place and regulate the use of this substance more fully.

With this lack of cultural norms in the use of alcohol, some dangerous patterns of drinking have developed in Indian groups. Two patterns have developed which particularly increase the difficulties of those who are potential problem drinkers or alcoholics. First is the use of alcohol as a focus for groups to develop. This in itself would not be harmful except that such drinking in the group often leads to the pattern of drinking until the supply of alcohol is exhausted or until the members of the group have become intoxicated. A great deal of sharing of alcohol exists within these groups, with strong pressures on the members both to be generous and to accept the generosity of others. Many problem drinkers question whether they will have any friends at all if they do not join in the drinking group. It is not unusual to hear a person attempting to give up alcohol ask the treating physician where he will find friends when he no longer drinks, since those with whom he regularly associates and shares other interests are usually drinkers.

Besides the function of alcohol to form groups, there is a second common and potentially dangerous use. Behavior which occurs under the influence of alcohol, especially aggressive behavior, is somehow less damaging to the individual in the eyes of the others. The same type of behavior while the individual is sober would result in discipline and disapproval on the part of other people, but is commonly tolerated with drinking.

Psychological-social factors

Uncertainties in social relationships may result in personality problems in later life, of which one manifestation may be excessive drinking. The causes of any person's drinking problem are highly individual and vary as much as do the personalities of the problem drinkers. Certain common Indian psychological problems, however, seem to contribute particularly to alcoholism. For many Indian problem drinkers, the use of alcohol seems to be their means of dealing with anger and frustration. Drunkenness releases and sometimes redirects pent-up anger. In some cases the anger originates in the feelings of frustration, worthlessness and helplessness derived from a real or imagined lack of autonomy. Many of these attitudes are related to problems of employment, unemployment and dependence on welfare assistance. The person who has no job at all has very little opportunity to prove himself. His problem may be compounded, however, if his wife is either the breadwinner in the family or occupies a job which has a higher status and a higher income than the ones to which he can aspire. The embarrassment and anger which many such men feel may then be expressed in excessive drinking.

In general, the average employed Indian male finds himself working in low status, relatively menial jobs, in which it is impossible to assert himself in any meaningful way. He often gets the feeling that people do not expect him to be able to give high quality performance, that they expect him to be unreliable and irresponsible. An individual with this type of pressure upon him may have very little open to him in most Indian communities except the solace and fellowship of the drinking group.

What is true for the average non-alcoholic becomes doubly so for the individual who has already had a problem with alcohol. For him the available jobs are even fewer, and the income lower. His job security is often extremely uncertain since such people are hired only in temporary and menial jobs. In some cases there seems to be little advantage in working as opposed to accepting welfare assistance; in fact, the welfare check might even be a more reliable source of income.

Many new industries coming onto the reservation employ only women, leaving the man at home with little responsibility and little opportunity to be the leader of the family. When men are employed they often work at the same jobs as women, creating still another unhealthy situation for the adult male. The result is the lowering of the man's feelings about himself as well as a mounting angry feeling about his wife and his general position in the world. Such feelings can certainly contribute to the onset of drinking, which in turn may lead to the breakup of family relationships and a resulting damage to the development of the children within the family. Women of course are also subjected to many stresses, not the least of which are the tensions which may result from an alcoholic husband. In general, however, the woman, because of her useful and traditional role in rearing the family, is usually less at risk for the development of alcoholism than the man in most Indian communities.

Some individual Indians and their families, often assisted by Government agencies, leave the reservation to find work in urban areas. Many are completely successful in making the adjustment and lead normal productive lives. For others, however, the change of environment brings new stresses in addition

to the old. Cut off from their familiar surroundings and their circle of friends and relatives, a few Indians do not successfully adapt to urban living. Many return home even more discouraged, while others drift into the slum sections of the city where increasingly harmful drinking may be the outcome.[23]

A final point is the lack of autonomy many Indians feel in dealing with the resources they consider to be their right, such as land holdings or funds held in trust. Restrictions on the Indian's use of these resources may also be a factor leading to anger and frustration and may contribute further to the Indian's feeling of powerlessness.

Although all of the factors just mentioned are damaging to adults, their effect on the adolescent and the child growing up in such a family may be even worse. The normal development of any adolescent boy or girl depends to a large degree of the model that the parent presents to the child. When adolescents and children see the powerlessness, and the lack of self-determination and autonomy in their parents and neighbors, which have developed as a result of many circumstances, they find it is difficult to find an adult with whom they can identify. The resulting frustration and anger which a child must experience often seem to find their relief in the use of alcoholic beverages. He begins to feel the same frustration and sense of inadequacy which he sees in many of the adults surrounding him.

Although the extent to which adverse psychological and socio-economic conditions in Indian communities foster excessive drinking should not be underestimated, it would be wrong to close this section without reference to the fact that there are many features of Indian life and culture which are real strengths. Solid family life, religion, and a sometimes extraordinary ability to bear physical and psychological hardship are qualities which help most Indians to bear successfully the very real stresses to which they are subjected in their daily lives.

Without these strengths it is quite possible that alcoholism might be an even greater threat to health and well-being of the Indian people.

SUMMARY

Alcoholism is one of the most serious health problems facing the Indian people today. This fact is now clearly recognized both by Indian leaders and by the Indian Health Service.

Historically, alcohol was introduced into most Indian cultures from the outside, among a people who had no traditional way of coping with it. The effects on health, family relationships and traditional society were profound and in some cases disastrous. Partly due to the efforts of the Indians themselves, the Federal Government banned the sale of alcoholic drinks to Indians from 1802 to 1953, although liquor always found its way, with the help of bootleggers, to those who wanted it. Since 1953, the sale of liquor to Indians has been a State or local tribal matter.

The adverse effects of alcoholism in the Indian population today are generally felt to be considerable but valid information is scarce. Special surveys have documented that the prevalence of drinking is high in many communities, that drinking is primarily a social activity and that intoxication is the common but by no means inevitable, outcome. Probably a majority of suicides, murders, accidental deaths and injuries are associated with excessive drinking, as are many cases of infection, cirrhosis and malnutrition. By far the majority of arrests, fines and imprisonments in Indians are for drinking or are the results of drinking. The associated loss of productivity and the resulting abnormal social adjustments are by-products of considerable importance.

Like most Americans, Indians usually have mixed feelings about their relationship to alcohol. Drinking to excess is not condoned but neither is it criticised by many Indians, so long as no harm is done to others. Many others feel that alcohol should be entirely banned from sale or distribution in Indian communities.

Alcoholism in Indians has in general many underlying causes. It is a means of coping with feelings of anger, frustration or boredom, all of which are related to the position in which many Indians find themselves today. Inferiority feelings about their lack of education, meaningful employment, status and economic autonomy which are characteristic of many Indian groups, are expressed in excessive drinking. These features of modern Indian life particularly affect the adult men and adolescents of both sexes. The latter group are further faced with unique problems in both the home and school environment, such as the breakup of family relationships (often due to drinking) and the disparagement in the schools of their parents' way of life.

Alcoholism, therefore, is a problem which deserves the best efforts of the Indian Health Service staff working not alone, but in conjunction with other agencies or groups who are concerned, and especially with the Indian people themselves, who more and more recognize the urgency of the situation.

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INTRODUCTION

The Indian Health Service Task Force on Alcoholism has prepared the present work as a guide to the development of more meaningful programs to deal with alcoholism at the local or Service Unit level. It is meant to assist health professionals to provide more effective services both to individuals and to communities with alcohol problems.

Most Service Unit leaders have had relatively little experience in dealing with alcoholism. Even the best trained physicians usually have not seen more than a few cases of DT's or acute intoxication, generally associated with injury in hospital emergency rooms, where the prevailing staff attitude is generally unsympathetic. Social workers, although familiar with the chronic alcoholic, often have an equally limited opportunity to see the ill patient. Neither has much chance to deal with the broad community aspects of alcoholism or has tried to devise a program to combat it. In addition, no matter how experienced in alcoholism Service Unit staff might be, they are usually unprepared for some of the patterns of drinking seen in Indian communities.

This guide, therefore, presents a brief outline of how a Service Unit might approach the problem of alcoholism in an Indian community.

It attempts to provide a balanced view between the comprehensive treatment of the individual and the broader community aspects of the problem, such as education, training, planning and program development. A truly successful program must contain all of these components in some measure.

The Task Force is well aware of the limitations of such a guide. Despite superficial similarities, every Indian community, like every other community, is unique and requires a careful assessment of local attitudes, resources, and many other factors before a program can be successfully developed. Service Units also, have vastly differing resources and hence capabilities for action. On the other hand, certain basic principles underlie what the Task Force believes is an adequate alcoholism program in any area. The details must in every case be worked out conjointly by the Service Unit, the Tribe, and the community.

DIRECT PERSONAL SERVICES

Alcoholism is very much a community affair and the resources of many agencies, groups, and individuals must be mobilized for its effective control. In most Indian communities, however, the IHS is the only resource which is equipped to provide direct personal services, particularly medical services, to the individual alcoholic. A community-wide program has little chance for success without the humane approach to the individual alcoholic which a good treatment program demonstrates. Open hostility, or ridicule and rejection are all too often apparent when busy health professionals are confronted with an alcoholic. Such attitudes must be replaced with a sympathetic appreciation of the patient as a person in trouble and with the realization that alcohol abuse is more likely a symptom of a deeper problem than a cause of the apparent one.

Health professionals must be careful about the tendency to moralize or make value judgments about alcoholism and its causes. On the basis of mortality and morbidity statistics alone, alcoholism is one of the most serious health problems facing the Indian people today and most Indian leaders have recognized this fact. Whether considered from the point of view of mental illness, cirrhosis, accidents, nutritional disorders, or infectious disease, alcohol is one of the most important determining factors of ill health. The Indian Health Service in attempting to raise the health of the Indians, can hardly afford to neglect alcohol and its impact on human health.

In the section that follows, brief attention will be given to each of the main types of direct personal services and to some guiding principles of comprehensive care of the alcoholic.

General Medical Care

No matter how elementary it may seem, it is a fact that proper treatment depends on proper diagnosis. And diagnosis, in the medical sense, means more than a passive acknowledgment that the patient smells of alcohol; rather, it is a recognition and subsequent confirmation that an individual is intoxicated, or has cirrhosis, or delirium tremens, or whatever the manifestations may be. Once a diagnosis of alcoholism is made, the physician has assumed a commitment to deal with the condition as he would with any other condition which threatens health or well-being.

Episodic treatment of the alcoholic has no place in proper medical management. Simple detoxification of a drunk is no more valuable than treating a child for pinworms, knowing that all his siblings also have the parasite. Treatment once undertaken, must be comprehensive and continuing. A plan should be devised for the alcoholic, assuring that he is properly followed up after he leaves the hospital and that he is referred to whatever community resources may be available and appropriate.

General medical care is usually provided first in the emergency room, where the patient may be

brought in with an injury, spell of unconsciousness, strange behavior, or any number of presenting features. Here it is of crucial importance for the physician to be alert for the effects of alcohol, which may be masked by other symptoms and signs. What is perhaps more common and more dangerous, the obvious signs of alcoholism may mask an underlying disease or injury of greater immediate threat.

Every physician has had the unpleasant experience of sending a drunk home to "sleep it off", only to learn later that the patient had a concussion, perforated ulcer, active tuberculosis, or any number of other dangerous conditions. Diagnostic evaluation of any person suspected of drinking must be unusually thorough and the physician's objective finding should be recorded.

The decision to admit a patient with acute or chronic alcoholism may be a crucial one for all concerned. An alcoholic with no other apparent disease should be admitted if there are suspected or apparent physical complications or when it is clear that intervention is needed to interrupt the drinking pattern. An intoxicated person is seriously at risk of injury or illness as a result of his drunken condition. It is therefore important that the emergency room physician be unusually cautious about sending a drunken patient home, especially a long distance or in inclement weather, even if his injury or illness is otherwise relatively minor.

Certain serious manifestations of alcoholism require hospitalization except in very unusual circumstances. Among these are alcoholic stupor, alcoholic coma, alcoholic hallucinations, convulsive seizures, and delirium tremens. Any of these conditions may be in themselves fatal or may lead to a fatal outcome as a result of complications. The full resources of the hospital are needed to treat them adequately. Certain organic complications of chronic alcoholism also require hospitalization, among which might be included acute hemorrhagic pancreatitis, hemorrhage from esophagael varices, and impending liver failure.

Once a patient is hospitalized, a few general principles of management apply. Physical restraint should be avoided unless it is absolutely necessary. The greater the force needed to subdue the patient, the greater is resistance and fright. When adequate nursing staff is unavailable, a member of the patient's family should stay with him if possible. Professional care, of course, must be provided by a nurse, if it is needed. Confused or delirious patients should, if possible, be kept out of large noisy wards. The room should be softly lighted, to avoid sharp shadows. Sedation must be minimal and should be for the benefit of the patient, not the staff. All members of the staff must be continuously alert for signs of complicating injury or illness, or an underlying depression. Finally, overtreatment, either with drugs, fluids, or other means, should be avoided.

For the most part, treatment of the manifestations of acute and chronic alcoholism is symptomatic. Mild sedation may be used in simple intoxication, tremors, hallucinations, or DT's, but must be strictly avoided in stupor, coma, or where a serious head injury may be suspected. Intravenous fluids are sometimes useful if the patient is dehydrated, but IV "cocktail" mixtures should be avoided.

Once the acute phase is over, the physician in charge of the alcoholic patient must consider a plan for long-term management, taking into account the resources available in the Service Unit staff, in the local community, or in the State. A patient admitted with any serious manifestations of alcoholism should generally be kept in the hospital for up to five days, during which time appropriate diagnostic studies can be carried out and the cycle of heavy drinking interrupted. It is usually a serious mistake to send a patient home as soon as his intoxicated state improves.

Long-term management may involve many things, such as follow-up in the out-patient clinic for counseling by the physician himself, referral to a psychiatrist or a social worker, or if available, a community alcoholism worker. If appropriate hospital resources are not at hand, suitable cases might be referred to the local Alcoholics Anonymous group or to a recovered alcoholic in the community who might be willing to help. Some clergymen are also eager to help in this type of situation.

The important principle, of course, is that the alcoholic badly needs attention beyond his immediate intoxication episode. If he does not get this kind of continuing help and interest, the hospital becomes just as bad as the jail with its "revolving door".

Psychiatric Care

Although psychiatry has an important part to play in the rehabilitation of many alcoholics, it is not a realistic view to depend on getting continuing psychiatric help for most alcoholics, except under unusual circumstances. The few psychiatrists available to the Indian Health Service can be best employed in a consultative or training role. Service Unit staff should request the area psychiatrist on his periodic field visits, to set up a professional training session for the doctors, nurses, social workers, and others concerned with the direct care of alcoholics. Here difficult cases might be presented for discussion.

Serious cases of chronic brain syndrome due to alcoholism or alcoholic psychosis should be referred to a mental hospital, if possible, for long-term care. Each Service Unit Director should become familiar with the procedures and qualifications for admission to the appropriate facility, with the help of the Area psychiatric consultant, if needed. In choosing a facility, the nearest Veteran's Administration Hospital should be considered if the patient can qualify for admission.

Social Services

In many Service Units, the medical social worker, if one is available, can be of invaluable help in providing direct care to the alcoholic patient. The social worker frequently is better trained in counseling techniques than the physician and in any case is often in a better position to provide for the care of the patient's needs once the acute medical compli-

cations are under control. The social worker should if possible see the patient while the latter is still hospitalized, then follow him regularly in the out-patient clinic either by himself or in conjunction with the physician. An occasional home visit is important not only to get a clearer picture of the patient's needs, but also to demonstrate the hospital staff's continuing interest in the patient's well-being.

The social worker would frequently be the most logical person to coordinate an overall plan for the alcoholic patient in conjunction with the physician and PHN, to see that he obtains whatever services he needs.

In Service Units without social workers, many of the necessary functions can be carried out, at least partially, by a cooperative arrangement with a BIA, County or State Welfare Worker, or with a local clergyman.

Nursing

Clinical nursing of the alcoholic, of course, is not essentially different from the care given to any actutely ill patient and the general principle outlined under "Medical Care" should apply to nurses. The Task Force clearly recognized that alcoholic patients may be not only unpleasant and surly, but in fact dangerous at times. Although there is no easy solution to this problem, some of the larger hospitals might consider employment of a male "medical attendant" to work evening and night shifts, in lieu of a nursing aide or even LPN. Such an individual could be of considerable assistance not only in the case of acute alcoholics but as a security guard, an emergency room aide, or someone who could help with the heavy lifting.

The Public health nurse has a somewhat different part in the comprehensive treatment of the alcoholic. She of course, is in the best position to evaluate the home situation and to report her findings to the physician and social worker. Since bad family relationships may cause, or aggravate, or result from the excessive drinking problem, it is essential to evaluate them at first hand. As with the infectious diseases moreover, it is not uncommon to find in the home of one drinker a second alcoholic who also needs help. Probably the most useful function of the public health nurse however, is her health evaluation of the dependents of the alcoholic, such as small children or perhaps the elderly, since these dependents are all too often neglected or even actively abused. Finally, there are those situations in which the public health nurse, by her regular visits and sympathetic interest, may be a vital force in maintaining sobriety in an alcoholic on active treatment.

Personal Services by Non-Professionals

In addition to the medical attendants already mentioned, some of the larger Service Units may want to consider employing alcoholism counselors for use not only in the hospital but in the clinic or the community. Such workers are usually local recovered alcoholics themselves and there is no question that in many cases they are able to establish a meaningful relationship with an alcoholic better than a health professional.

An alcoholism counselor, after a suitable period of training, may provide the patient with that crucial link between his own seemingly overwhelming problem and the professional help which is available if he could bring himself to use it. The counselor is probably also the most effective follow-up worker—perhaps the only member of the Service Unit staff who would have free access to some homes. Such workers of course, are not necessarily employees of the hospital or health center. In at least one area, a Community Health Representative serves as an alcoholism counselor. Elsewhere such people may be members of the local Alcoholic Anonymous group or simply volunteers. Several of the programs of the Office of Economic Opportunity have trained and paid such counselors as well.

Personal Services Outside the Community

A few States now provide special rehabilitative centers for alcoholics using the most modern comprehensive treatment approach. In some situations a patient may qualify and be suitable for such a program.

All States have some program of vocational rehabilitation for its citizens and although frequently alcoholics are excluded, this is not necessarily the case. The State psychiatric hospital may also offer such a program.

Certain urban centers may provide cooperative group living services for alcoholics, or else "half-way houses" as a transition between the more sophisticated treatment center and the patient's home environment.

In considering all of these off-reservation facilities, it is important to balance the advantages of group living and "therapeutic environment" with the "cultural shock" which most Indians will experience in an urban setting among a group of alcoholics with attitudes, patterns and problems somewhat different from his.

It should be clear from the foregoing that the treatment of an alcoholic must go considerably beyond the stage of detoxification. Although the phsyician has the major responsibility for the care of the individual patient, he has not adequately fulfilled this task unless he has devised a total plan for the patient, using all the available resources of the Service Unit and the community. Perhaps the two greatest flaws in the management of the alcoholic today are the failure to appreciate alcoholism as a threat to health, and the failure to provide comprehensive care to the alcoholics who are diagnosed. Both of these flaws can be largely remedial by a change of attitude toward the problem drinker on the part of the entire Indian Health Service staff. Positive leadership in this respect must begin with the Service Unit Director and be fostered at all levels and through all professional categories.

TRAINING

The term "training", as used in this Guide, refers to educational programs or activities which are devised for those who provide services to alcoholics and/or their families. The importance of a coordinated training program in alcoholism for physicians, nurses, social workers, and other health workers at the Service Unit cannot be overestimated. Any such training program should also include, if possible or if appropriate, local teachers, ministers, BIA officials, Tribal Councilmen, and other community leaders. In an area where contract medical services are widely used, contract physicians and nurses should be urged to participate as well.

The content of a training program should include as a minimum: 1) How alcoholism affects individual men and women and how it affects the local community; 2) What are the local, actual and potential, community resources for the prevention and treatment of alcoholism, and how they can be utilized most effectively; and 3) What are the available clinical techniques for the treatment of alcoholism and which would be most suitable for the local situation.

Training may take a variety of external forms depending on the needs and resources of the Service Unit. Workshops, courses, and other longer sessions will usually be held at the area offices, the IHS Training Center or on a university campus. The area office should keep the Service Units informed on the availability of such courses, and the necessary arrangements for attending them. Smaller study groups or individual lectures and seminars are best held at the Service Unit where a greater attendance can be expected and where local problems and applications can be explored in greater depth. On a still less formal scale medical or nursing staff meetings at the hospital or clinic can be devoted to alcohol problems from time to time. In every case it is best to have a well planned presentation, case report or a film as a basis for the discussion.

Costs of a training program of course, will depend largely on the scale in which it is undertaken. Staff meetings take time only. Local lectures and seminars can usually be handled by the Service Unit since the only direct costs are likely to be no more than a small travel expense or honorarium. Speakers interested in alcoholism are usually only too happy to be invited. The larger meetings, such as symposia, conferences and workshops are best handled with the help of the area office. Funds are sometimes available, either for the sponsorship of one of these meetings, or to defray the costs of those attending, if it is held away from the Service Unit.

A partial list of possible sponsors of alcoholism training programs would include, in addition to the Indian Health Service, the State Health Department, Association of American Indian Affairs, Arrow Inc., the Office of Economic Opportunity, National Council on Alcoholism, the National Institute of Mental Health and the Bureau of Indian Affairs. Several universities, notably the University of Utah, have been particularly interested in Indian alcoholism and have sponsored special summer training programs.

The resources of a Service Unit for the care and prevention of alcoholism can often be considerably augmented, and at very little extra cost, by the training of existing staff, volunteers or other persons already working in related fields in the community. Both initiative and ingenuity are required to devise a suitable program, but frequently the resulting improvement of attitudes and services will be well worth the effort.

HEALTH EDUCATION

Health education is another basic component of any alcoholism program. In this guide, health education means the dissemination of reliable information on alcohol, alcohol use and alcoholism to individuals, groups, organizations and agencies within the community. It may be the job of all members of the Indian Health Service staff at various times, in various places, or under various circumstances. It is also the job of others in the community such as teachers, social workers, law enforcement officers, judges and clergymen, to name a few.

Health education has in the past been the hope, and often the only hope, of many individuals and organizations for the control of alcoholism. The theory is that if a person knows the truth about alcohol and its dangers he will not drink, or at least he will not drink excessively. Every State in the country has a law on the books requiring "alcohol education" in the schools, but no one seriously believes that these laws have been effective in preventing the abuse of alcohol either in school or in later life.

The reasons for the failures are complex. In part, of course, they are related to the ambivalent feelings which many persons have about drinking in their own lives. A teacher with a strong religious upbringing and who looks upon drinking as morally wrong is likely to be just as ineffective in teaching about alcoholism as one who has a drinking problem in his own life and is trying to hide it. Too often "scare techniques" have been used to encourage total abstinence - archaic restrictive laws, especially on Indian reservations, have complicated matters further, especially in communities where these laws are frequently violated. Finally, there is all too much emphasis on "alcoholism" rather than on "drinking" in conventional health education programs.

In short, perhaps too much has been expected of health education as the main or even sole support of an alcoholism program. It is an essential component, to be sure, but it must be carried out with the proper contact, by the right people, and under the right circumstances if it is to do more good than harm. Alcohol education cannot be legislated or forced.

Health education presentations must be appropriate to the goal to be accomplished and the most effective speaker may vary with the circumstances. For example, there are many times when a recovered alcoholic can make a far greater impact than a

physician with a patient seeking to overcome his problem with alcohol.

In general, alcohol education can profitably be directed toward nearly every individual or group in the community, provided it is done in a rational manner. Hospital employees, particularly nurses' aides, food service workers, housekeeping and laundry workers, and maintenance men all usually come in contact with alcohol abuse at some time, either in their own lives or at work, and they should be prepared to deal with it. Employees of other agencies, notably the Bureau of Indian Affairs, should also be included whenever possible in a teaching program. School officials, both teachers and administrators, are an extremely important group to reach with a sound and up-to-date knowledge of alcohol and its effects. If a local industry employs Indians, supervisors at all levels need to be equipped with a deeper knowledge of alcoholism than most already possess. Finally, of course, education must be directed toward individuals and groups within the community. Alcoholics Anonymous, Al-Teen and Al-Anon are three worthy organizations which are devoted largely in one form or another, to alcohol education, particularly for alcoholics themselves, or for their families. Such groups should be actively encouraged or supported by the Indian Health Service staff since they can add a dimension to alcohol education which the health professionals can rarely provide. Other groups, such as youth clubs, men's and women's organizations should also be helped to sponsor an occasional program on alcohol.

It has been said that the transmission of alcohol information in the past has been outstanding it is just that no one has been tuned in on the right frequency to receive it. This communication problem must be kept constantly in mind when a health education program is being devised. "Moralizing", "scare techniques", and "threats" are hardly ever effective in making a lasting impression. Instead, it is recommended that some of the following principles be kept in mind.

1. It is not essential to drink. A person who abstains from alcohol should not be excluded from a social group.
2. Excessive drinking does not indicate maturity or masculinity, any more than eating an excess of food.
3. Uncontrolled drinking or alcoholism, is an illness and requires the proper medical treatment. It is not the result of perversity, character defect or immorality.
4. Safe drinking depends on a number of factors such as
   a) the early development of health attitudes toward drinking,
   b) the prevention of dangerous blood alcohol levels by the spacing and dilution of drinks and the concomitant use of food, and
   c) the recognition that drinking is dangerous when used to solve emotional problems.
5. Intoxication is not necessarily the outcome of drinking. In every way possible, the attitude that intoxication is an undesirable effect of drinking and is not socially sanctioned by the group, should be engendered.
6. Alcohol, even in small quantities, has certain adverse physiological effects on the body and may interfere with important tasks such as driving or working.

In most Service Units, the Health Educator if one is available, would be the logical coordinator of an alcohol education program, but it could just as well be a medical social worker, public health nurse or physician; depending on his or her skills and depth of interest. Among the methods which should be considered by this individual might be:

1. Arranging for speakers either from the local community or from outside.
2. Ordering films, slides or tapes for use in staff or public meetings.
3. Organizing and/or supporting local study groups among youth or adults, including Alcoholics Anonymous, Al-Anon and Al-Teen.
4. Arranging for group tours to certain institutions, such as jails, prisons, mental hospitals and special treatment centers.
5. Providing local news media with articles, spot announcements and other materials on alcoholism.
6. Discussing with school administrators the significance of the alcohol problem and helping them to devise meaningful alcohol education programs in the school and community.
7. Working closely with the managers of local industries.
8. Developing appropriate materials (displays, exhibits, workshops) for use at conferences of teachers, law enforcement officers or tribal groups.

COMMUNITY RELATIONSHIPS

This chapter deals with the Indian Health Service's role as a catalyst for new community programs and a modifier of existing programs. In this role we are consultants, technical advisors and enablers for achieving things in a community alcoholism program planning.

Each Service Unit should designate one person as coordinator for all alcoholism activities. This individual will be responsible for interagency coordination and for overseeing all alcoholism planning to help assure that program objectives are met. He will also be the Service Unit staff member with the primary responsibility for initiating and sustaining community interest and action in alcoholism programs. The position is one of liaison between the community and the IHS staff, as well as the main Service Unit link with the Area Alcoholism Program Officer or his equivalent.

The role of the Indian Health Service in alcoholism treatment and community action must be developed in conjunction with and approved by the tribal governing bodies. To have any success, it must have their constant input and special knowledge.

They should also take an active part in implementing these plans. To achieve this essential tribal participation each Service Unit should work with the tribal governing bodies to appoint an Alcohol Pro-

gram Advisory Committee. This committee will act in an advisory capacity to the program, and should not be confused with any existing Community Council on Alcoholism or with such a council that might be formed in the future, although some of the members might serve on each body. The advisory committee would serve as the voice and hand of the tribe in direction and implementation of their own program. Although the advisory committee and total staff will work closely together, an especially close working relationship should be maintained between the Service Unit Coordinator and the Indian Advisory Committee.

Before we can assist the community with developing alcoholism treatment and prevention programs, or in giving effective professional consultation and support to existing programs, we need to tackle feelings about the alcoholic himself and his treatment. The priorities and treatment methods outlined in other sections of this document should be carefully followed. The attitude and concern of the entire staff toward this problem and toward the people afflicted with it influence very directly the feeling of the rest of the people of the community. Service Unit personnel should promote preventive programs and show their concern about the proper care and treatment of problem drinkers in the whole community, not just in our own medical facilities. Each staff member should have an "open door policy" for those people suffering from alcoholism or whose lives are touched by it.

The active involvement and participation of the Service Unit staff in community affairs, particularly those concerned with alcoholism, can help determine healthy community attitudes toward the patient who has achieved sobriety and is making a new situational adjustment. The attitudes of health professionals toward alcoholics and alcoholism can go a long way toward favorably molding public opinion.

Natural friendship, warmth and ready acceptance are of primary importance to the alcoholic under treatment. Both frequent contact and sincere concern for the new demands placed on him in his new life will help him through a difficult period. He should be invited to social functions and be made to feel comfortable in attending them. One of the most effective means of helping the alcoholic maintain sobriety is to involve him in activities which are related to the treatment and prevention of alcoholism in the community. He can be of assistance in planning meaningful programs as well as in counseling those individuals who are seeking help for an alcoholism problem themselves.

The alcoholic under treatment of course needs help beyond the hospital and clinic. Job placement, training, welfare, transportation are all areas which need attention in most cases. The alcoholic needs the assurance that people are interested in him and are willing to support fully his efforts to help himself.

Each Service Unit should inform community services, religious groups, legal and governing bodies, and other organizations of all their activities related to alcoholism treatment and control. Its willingness to cooperate with them in their ongoing programs should be explicitly clear; as should its intention to assist them in program improvement or the initiation of new programs. The Service Unit should also work with other resources as consultants, in planning for meetings and conferences, in staff education programs and individual case management.

The staff should also participate in other community planning not directly related to alcoholism, such as industrial development and school problems. An example might be a new reservation industry with management that is fearful of drinking problems in the existing labor pool. The Indian Health Service staff can offer advice and consultation on the extent of the problem, how the problems can be dealt with, availability of certain treatment services, and in setting up an industrial alcoholism program if desired. Similar services can be offered to schools regarding their program and methods in relation to behavioral and learning problems of children.

An integral and necessary part of any work with other agencies and resources is an adequate, workable, well defined method of accepting and referring cases. To do this it is essential that all organizations such as those suggested above know the Indian Health Service policies and procedures for accepting patients for treatment services. It must not be assumed that they know those policies, but each agency should have a written outline of the procedure to be followed. In addition, the Service Unit should also keep an up-to-date resource file, which can be developed by personal contacts with community agencies and by making written notes of their intake and referral policies for alcoholics. The Indian Advisory Committee will be involved in giving assistance and impetus in setting up the methods and procedures for planning and evaluating the alcoholism program.

Each Service Unit must be responsible for providing needed consultation and technical assistance on treatment of alcoholics, community program improvements and program development to community organizations and agencies, including information regarding possible funding for new programs. The aim should be to supplement and support existing alcoholism programs which have real or potential value in the community.

The preceding section has attempted to set the mood and direction of the Service Unit's program, feelings, intentions and actions regarding alcoholism and to define its relationship with other agencies. The Service Unit Coordinator and the Indian Advisory Committee have a further essential and active role—to organize the community to action about alcoholism as a major health problem.

To do this effectively, it is necessary to identify the Indian people in the community who are most interested and can provide leadership. To find these people may be difficult, but perhaps the first step would be to discuss the matter with the Indian Advisory Committee and other tribal leaders, explaining the problem and asking their help. If these ideas are acceptable to the community, the leadership for the program should identify themselves before long. The Service Unit staff must respect their advice and

leadership in how to proceed. One of the first things to come may be a Community Alcoholism Council made up of these people.

The Indian Health Service Task Force on Alcoholism is preparing a reference guide for community leaders listing all types of alcoholism programs, and containing a brief summary about the assets and liabilities of each program. It also contains information on resources available to develop these programs. The Service Unit staff should be prepared to interpret this guide for the Tribe when necessary.

DATA COLLECTION, RESEARCH, AND EVALUATION

In the first section of the Alcoholism Task Force Report, the difficulty in finding meaningful statistics about Indian alcohol problems was pointed out. The situation is even worse with respect to information on the effectiveness of treatment. It is therefore extremely important in establishing any program to set up first the means of data gathering, as well as to build into the treatment program a means of continuous evaluation of that program.

The recent trend toward the use of problem-oriented health records in the Indian Health Service will in the future provide a method of data collection which will be helpful in defining the extent of alcoholism as well as many other disease entities. At present, however, there are a number of other means which can be used to collect data. A rough incidence figure on inpatient cases of alcoholism could be obtained if upon discharge of the patient the physician diagnosed any existing alcohol problem within the first four discharge diagnoses. Similarly, on pediatric cases it would be well to mention if alcoholism in the family was a contributory factor to the primary illness. Since alcoholism is rated as high priority health problem, it seems reasonable to include it in the first four diagnoses. These cases could then be tabulated by age, sex and residence on Service Unit, area and headquarters levels, thus giving us a more accurate picture of the total problem. Alcohol related problems should also be more frequently diagnosed and tabulated from the outpatient clinics.

Another use that could be made of such data coming from both inpatient and outpatient sources would be the creation in each Service Unit of an alcoholism registry. This could be constructed very similarly to the tuberculosis, cancer or venereal disease registries now in existence. From this, in addition to the statistical information it would provide, various prevention and treatment programs could be constructed, aimed directly at the involved patient and his family.

In addition to the necessity of gathering prevalence and incidence data, there is a need to evaluate the demand made on professional time by patients with problem drinking and alcoholism. This is particularly important in the outpatient department. Each Service Unit could establish a simple recording sheet which would be used each time a patient is seen for a problem directly related to alcoholism. This record should be compiled by anyone having contact with a problem drinker, such as doctors, nurses or social workers.

The outpatient department is also an important source in determining the involvement of alcohol with accidents. In the tabulation of the previously described contacts, it would be important to note specifically the association of an accident with alcohol. A final source of information could be death certificates. It is recommended that alcoholism be specifically included as an associated cause of death whenever appropriate.

The above recommendations pertain primarily to information gathering within the structure of the Indian Health Service. There is a great deal however, to be learned from other agencies. These organizations include Tribal governments, BIA, State and municipal groups, as well as those facilities used by the Indian Health Service for contract medical care. Cooperation should be enlisted at all levels with the various organizations. It is hoped that a brief reporting form can be used by all the agencies and organizations mentioned, to serve a dual function, namely assistance in data gathering as well as means of patient referral.

The coordination of information from these forms would probably best occur at the area level by an alcoholism program officer. This person should receive a copy of the form made out on any patient whose home residence is in that area. The copies could come from all the sources mentioned.

It is important to stress again that any alcoholism program which is developed will depend on valid data for the intelligent evaluation of effectiveness. Both accurate baseline data and the continuing impartial assessment of treatment outcomes are essential.

Further improvements over and above what has been suggested will be dependent on a total upgrading of the Public Health Service record system. In the Indian Health Service at least, this process has already begun. In the not too distant future, we will be able to have easy access to statistics on alcoholism as well as other illnesses. The increasing use of computers in record keeping will make this increasingly possible. Until then however, a great deal can be accomplished by a full use and correlation of the information already available from many local sources.

A SUGGESTED APPROACH TO PLANNING

Implicit throughout this guide is the concept that alcoholism programs do not just happen, but rather are planned, funded, implemented, and evaluated through a conscious and rational process. By way of summary, this section will outline briefly the necessary steps to the development of an alcoholism program in the community. These steps of course, are not arranged in a rigid order of application.

1. Recognize the problem of alcoholism for what it is; that is, a significant cause of mortality, morbidity and general community disintegration. This step, obvious as it seems, is rarely taken in more than a half-hearted manner. Leadership, if not

already assumed by others, should be taken by the Indian Health Service.

2. Collect data on the extent and effects of alcoholism locally. It is essential that the data be available as a basis for rational planning and evaluation. Although frequently, accurate figures do not exist, a reasoned and informed judgment from the sources as outlined in part VI is a good starting point. More sophisticated methods of data collection must be developed as the program itself develops.
3. Involve the leadership of the community early and listen well to their advice and counsel. No matter how elaborate and theoretically sound a program may be, it will fail spectacularly if it is at cross-purposes with the local needs and attitudes of the people. Not only Indian leaders should be consulted, but also representatives of other organizations and agencies concerned with the problems of alcoholism.
4. Determine the magnitude and characteristics of the local alcohol problem, in cooperation with community leaders and resources. The specific nature of the local problem needs careful definition, such as the epidemiological patterns of drinking and barriers to progress.
5. Take a careful inventory of locally existing resources for the recognition, treatment and prevention of alcoholism and identify the gaps in services available for alcoholics and their families. Strengths of the community are as important as the weaknesses in this regard.
6. In conjunction with the local Indian leadership, set goals and objectives for the type of new program the community wants and needs. Such goals and objectives must be realistic and reflect what the community is prepared to support.
7. Work out, with consultation from the area staff, a community alcoholism council or alternative plans of action which would be needed to accomplish the goals and objectives which are established. Such plans should include a realistic estimate of cost, taking into account existing space, staff, and time as well as outside resources which might be utilized. Plans should be comprehensive, with attention to training, health education, data collection, and community action, as outlined in the guide.
8. Choose, with the advice and approval of the Tribal Council, the best alternatives for action and submit the entire plan to the area office, including cost estimate, goals and objectives. The plan chosen for adoption should incorporate a means by which the programs can be evaluated.
9. Implement the approved plan immediately to the extent possible. Any comprehensive plans for alcoholism will include aspects which do not involve the expenditure of money or acquisition of other new resources. These parts of the program should be initiated as soon as possible, not only to lay the groundwork for future efforts, but to show good faith to the Indian community and to the area office.
10. Implement the whole plan as soon as extra resources become available. It is important to keep the Tribe informed of progress in implementation. They have a right to know about the progress made as well as the delays and frustrations encountered. It is quite possible that pressure to bear by the Indian people will be a most effective way of expediting outside funding.
11. Evaluate the program objectively by comparing results with baseline information and measuring the extent to which original goals and objectives have been met. Evaluation should be done in close cooperation with the Tribal Advisory Group.
12. Revise goals, objectives, and plans in light of the new experience gained from the evaluation and the continued operation of the program.

Throughout these steps it may be inferred that planning and program development for alcoholism is the sole or even primary responsibility of the Indian Health Service staff. This inference is not necessarily correct. The planning process ideally should originate and develop within the community itself, with the Indian Health Service providing technical support and consultation only. The steps outlined here in essence describe a process which any planning group must undergo to accomplish any type of program. The Indian Health Service however, with its health professionals and its physical facilities, is in a unique position to provide the kind of direct or indirect leadership or stimulus necessary, not only to recognize the need for an alcoholism program, but also to assist in a significant way in its development and operation.

Section III—Reference Guide for Indian Tribes and Communities Wishing to Undertake Alcoholism Projects (April 1970)

INTRODUCTION

This guide was written to help Tribal Councilmen, Health Board Members, Community Health Representatives, and other members of Indian communities become better informed on alcoholism as a health problem and to take action needed to prevent or control it. This booklet will provide information on what alcoholism is, what can be done about it by modern treatment methods, and how Indian people might find out more or gain support for a community alcoholism program.

The Indian Health Service is greatly concerned about alcoholism as a health and social problem and its staff stands ready to assist Indian communities in any way possible to develop a suitable program to combat it. Alcoholism has been given a high priority by the Service just as it has by many Indian leaders across the country. It is a problem which can be solved only by sincere interest, hard work and cooperation.

This guide has three parts. The first is a list of definitions of common words used in books and papers on alcoholism. A great deal of reading material on alcoholism is available. This glossary may help with some of the medical and technical words. The second part is made up of short descriptions of a few of the modern methods of treatment for alcoholism. Many people either feel that alcoholism is incurable, or else they expect more of drugs, hospital care or other treatment than is possible. This section may help clarify these matters. The third part is a list of organizations and agencies which can provide information or consultation on alcoholism and in some situations, financial support for community alcoholism programs. Addresses have been supplied wherever possible so that the organizations may be contacted directly.

MEANING OF COMMON TERMS RELATED TO ALCOHOLISM

The list of words below contains many terms which are commonly used in writings on alcoholism. The definitions given here are short and refer only to the meaning of the word which applies to alcoholism.

Abstinence: Not using alcohol.

Addiction: Not being able to stay away from alcohol or some other substance, such as drugs. An *addict* by himself can not give up his habit without bad effects such as "shakes," abdominal pains or nervousness. *Addicts* can be helped by medical treatment, but they have a serious problem and must recognize it as such.

Alcohol: A type of chemical which can be made by several processes from fruits, vegetables, and other substances. It is a colorless liquid and burns freely. Alcohol is present in all intoxicating drinks, although some kinds have more alcohol than others.

Alcohol, ethyl: Ethyl alcohol, sometimes called "ethanol" or "grain alcohol" is the kind found in all intoxicating drinks. Distilled liquors, such as whiskey, rum, and vodka, have the greatest amount of alcohol, while wine and beer have much less, but enough to be harmful in large amounts.

Alcohol, isopropyl: Isopropyl alcohol, or "rubbing alcohol" is the kind used in hospitals for cleaning and sterilizing the skin. It is made as a by-product of the oil industry. It is not safe to drink.

Alcohol, methyl: Methyl alcohol, also called "methanol" and "wood alcohol" is used in industry to dissolve other materials, for cleaning and other purposes. It is *extremely dangerous* to drink and may cause death, blindness and brain damage, even in small amounts. "Denatured" alcohol contains methyl alcohol and must not be drunk.

Alcoholism: Alcoholism has been defined in many ways by many people. The IHS Task Force on Alcoholism suggests this definition:

"A disease, or disorder of behavior, characterized by the repeated drinking of alcoholic beverages, which interferes with the drinker's health, interpersonal relations or economic functioning."

Antabuse: Also known as disulfiram. A drug which serves to discourage the patient from impulse drinking. When this drug is taken regularly, the ingestion of alcohol causes a highly unpleasant reaction, characterized by transient hypertension, (high blood pressure), then a quick fall in blood pressure, flushing, rapid heartbeat, nausea, vomiting, shortness of breath, and sometimes, collapse. These symptoms are followed by drowsiness and recovery after sleep.

Ascites: A condition in which fluid builds up in the abdomen. It is usually caused by liver damage or cirrhosis, due to alcoholism. (see cirrhosis)

Black-outs: A brief loss of memory during and after a period of heavy drinking. These losses are often not noticed by other people, but the drinker may become aware later that he does not remember where he was or what he was doing during the period of drinking. Black-outs are a serious sign of alcoholism.

Blood alcohol-level: Amount of alcohol in the blood. This may be found by a chemical test on a blood sample. A level of 0.05% is not generally harmful, whereas a person with a level of 0.15% is considered in most States to be too intoxicated to drive a car. Levels of 0.30% to 0.50% may cause unconsciousness or death.

Cirrhosis: A disease of the liver which is usually caused by heavy drinking over a long time. Poor eating habits in alcoholics may also be a partial cause. In cirrhosis (sometimes called "Laennec's cirrhosis") there is often a scarred, shrunken liver, fluid in the abdomen, jaundice and bleeding from the esophagus, the passage way from

the mouth to the stomach. (see varices, esophageal) It is usually fatal.

Coma: Deep loss of consciousness. Normally a person in a coma cannot be awakened by calling, shaking, etc. Coma may be caused by heavy drinking and other conditions. Alcoholic coma is a serious sign and may lead to death without proper treatment.

Delirium Tremens: Usually called "DT's" or "shakes" is a serious sign of alcoholism. It consists of trembling, sweating, fear, restlessness and confusion of the mind. Usually the victim sees insects, small animals, snakes or other frightening things. DT's is a very serious condition which requires treatment at once in a hospital. Even with the best treatment many people die from this condition.

Dependence: A need or craving for alcohol or a certain drug to which the mind and body have become accustomed and without which proper function is almost impossible.

Detoxication: The medical treatment for serious drunkenness. This usually takes place in a hospital or special facility and may consist of injecting fluids in the vein, giving drugs to calm the patient, and rest.

Distillation: A chemical process by which certain alcoholic drinks are made. Distilled drinks have alcohol contents as high as 60%. Examples of distilled drinks are whiskey, gin, brandy, vodka, and rum. These are the most potent types of alcoholic beverages.

Disulfiram: Also known as Antabuse. A drug which discourages a patient from impulse drinking. (See Antabuse)

Fermentation: A chemical and biological process in which certain fruit and grain extracts are changed into alcohol. Beer, wine, ale and "home brew," are examples of fermented drinks. They usually contain between 5 and 10% alcohol.

Gastritis: A condition in which the stomach lining becomes red and swollen, causing pain in the upper abdomen. Gastritis may be caused by heavy drinking.

Hallucinosis: A disorder of the mind in which the patient sees, hears, smells or tastes something which does not exist. There are several causes, one of them being alcoholism. It is a serious sign in an alcoholic and requires immediate medical treatment.

Intoxication: Drunkenness, or the state of being drunk. This word is sometimes used for other kinds of poisoning as well as too much alcohol.

Metabolism: The process by which alcohol or other substances are broken down by the body into simpler substances so that they can be used or rejected by the body.

Pancreatitis: A disease state of the pancreas, a large digestive gland in the abdomen. The organ is swollen, inflamed and at a later stage scarred. The state causes severe abdominal pain and vomiting, and may be fatal. The excessive use of alcohol frequently leads to pancreatitis.

Proof: A measure of the alcohol strength in a drink. One half of the "proof number" is the percentage of alcohol. For example, "90 proof whiskey" contains 45% alcohol.

Sedative: A drug used to quiet or calm an excited or overactive patient. Sleeping pills are examples of sedatives.

Spree or binge drinker: This term is applied to the person who occasionally becomes drunk for short periods but can stop drinking anytime he wants. Such people are often injured when they are drunk. Equally often, unfortunately, they may injure other persons who have not been drinking.

Stupor: Severe drunkenness, at a stage when the person is unable to continue drinking. In this condition a person may come to harm by exposure, injury or choking.

Tranquilizer: A type of drug which helps some kinds of nervousness. It is sometimes used for alcoholic patients who are frightened or unable to relax.

Tremor: Uncontrolled shaking of the fingers, hands or other part of the body. A tremor is often seen in chronic alcoholism and is a serious sign.

Varices, esophageal: These are widened or "varicose" veins of the lower end of the esophagus, the tube connecting the mouth and stomach. They are usually caused by cirrhosis (see "cirrhosis") of the liver, one of the complications of severe alcoholism. If these veins bleed, they may cause death.

Wine Test: Used to test a patient's reaction to alcohol after he has taken Antabuse. It is usually given in a hospital using wine, or beer or any other suitable alcoholic drink. The test enables the alcoholic and the doctor to see how severe the reaction could be if alcohol is taken.

Wino: A slang word for a chronic alcoholic, especially one who drinks large amounts of wine.

Withdrawal: The drying-out stage of chronic alcoholism. Withdrawal is sometimes accompanied by the DT's, tremors or extreme restlessness.

PROGRAMS FOR THE TREATMENT AND PREVENTION OF ALCOHOLISM

The following pages describe various methods, programs and facilities which are used for the treatment and prevention of alcoholism. Not all of these are available in all parts of the country at the present time and it is best to ask at your local hospital or clinic, if you are interested in learning more about such programs in your area.

Medical Treatment

Drugs

Drugs of various kinds are sometimes prescribed by doctors to help in the treatment of alcoholism, but there is no medicine which will cure alcoholism. Certain drugs, properly used, can relieve some of its effects for a short time. Some drugs themselves can cause dependence, just as alcohol does, if they are used in high doses for a long time. It is of great importance that the alcoholic patient follows the doctor's directions carefully in taking the drugs prescribed and that he never tries to use someone else's medicines, which may be harmful to him.

Antabuse – Antabuse, sometimes called "disulfiram," is a drug which is sometimes used to help an alcoholic give up drinking. When taken regularly, it causes a person to become violently sick with headache, nausea, and vomiting whenever he or she drinks alcohol in any form. Antabuse can only be obtained through a hospital or clinic and only while the patient is under the regular care of a doctor.

When a doctor prescribes Antabuse, he must first be sure that the patient is seriously interested in giving up drinking and that he will follow directions carefully. The doctor then must determine by a careful examination and by some laboratory tests whether the patient has any other serious illnesses which might be made worse by the effects of the drug. Usually this examination is performed in a hospital over a period of five days or more. If the patient is found suitable for

Antabuse treatment, he is usually given what is called the "wine test" - first the drug and then some wine, beer or other alcoholic drink. This is done in the hospital because it is important both for the doctor and the patient to know what kind of reaction the patient will have when he or she takes alcohol following the drug. After discharge the patient must attend the out-patient clinic regularly for a check up and to get a new supply of medicine as needed.

Antabuse may help a few persons to give up drinking but is not a "wonder drug" by any means. It can be dangerous and must be used with great care by both the doctor and the patient.

Sedatives – This is the type of drug most people know as a "sleeping pill." Other drugs of this kind are used to help quiet down a very restless or overactive patient, or simply to relieve some of the "nervousness" often seen in persons with an alcohol problem.

Tranquilizers – Tranquilizers have many of the same effects as the sedative except that they are not so likely to cause drowsiness. Tranquilizers may be used to calm down an excited or frightened alcoholic while the effects of alcohol are wearing off. Usually they are not used over a long period of time in cases of alcoholism.

Other drugs – Frequently a doctor will prescribe other kinds of drugs for an alcoholic, but usually these drugs are for treatment of a complication of the condition rather than for alcoholism itself. Examples might be the use of antibiotics such as penicillin, for an infection or vitamin B shots for nutritional deficiencies that many alcoholics have.

Psychotherapy

This is a form of medical treatment for an alcoholic usually given by a psychiatrist. Basically, psychotherapy involves the doctor and the patient talking together privately on a regular basis. The purpose of the treatment sessions is to help the patient understand his feelings and the reasons why he behaves in the way he does. The doctor explores with the patient, ways other than drinking that he can learn to live with his underlying problems.

Psychotherapy can help many patients but unfortunately, it takes a lot of time both for the psychiatrist and the patient. Psychiatrists are in short supply all over the country and it is not likely that many Indian communities will have the regular services of one for many years to come.

Facilities

There are many kinds of facilities used in the treatment of alcoholism, some of them highly specialized. One thing that all facilities have in common however, is their expense. Treatment of an alcoholic in any hospital or special treatment center is extremely expensive. What is even more frustrating is that most of these facilities, particularly the specialized hospitals, have a long waiting list of patients.

Because of the expense and the difficulty of getting treatment in these special centers, the doctors must choose very carefully, from the many eligible patients, the ones who are most likely to be helped by the treatment which is offered. The patient in turn must be willing to cooperate in every way to help himself overcome his alcohol problem.

Detoxication Center

This is a facility used only for the treatment of intoxication, or drunkenness. The people who staff such a center are trained to help the intoxicated patient get over his dangerous state of alcohol poisoning as quickly and as safely as possible. The methods which are used include fluids in the vein, certain types of drugs and restraints if necessary. Detoxication centers are fairly new in this country and are found mostly in large cities. For the most part, they do not provide preventive services or any treatment for the long-time alcoholic who wants help in giving up his habit.

Half-way House

A half-way house is a facility which provides food, shelter and care for the alcoholic after he has been discharged from a mental or special hospital for alcoholics and before he returns to his home. Sometimes an alcoholic may go directly to the half-way house from his home community without going to the hospital. Most half-way houses are in cities, but there is no reason why one could not be established in a reservation community if the need were great enough.

A half-way house usually has 15-20 residents who are all former alcoholics or alcoholics under treatment for their condition. Everyone works together to obey the rules of the house, to maintain and clean it and do the cooking. Drinking is of course strictly forbidden. In addition to social events, most half-way houses have an educational program and offen have visiting speakers. Group meetings such as Alcoholics Anonymous may be held at the house regularly.

General Hospital

A general hospital is one which deals with illnesses of all kinds. All the Indian Health Service hospitals, except for two tuberculosis sanatoriums, are of the general hospital type. Most small hospitals do not have specialized facilities for alcoholics. Instead, such patients must be treated along with many other types of patients, usually in the medical ward. It is easy to understand how a noisy, intoxicated patient can disturb other sick patients and how difficult it is for a nurse to try to control him. No matter how much the alcoholic may need help and treatment, it may not be possible to admit him to the hospital without endangering the other patients or the nursing staff.

Several of the large Indian hospitals are now developing special wards for the treatment of alcoholics. At least one of these is under the direction of

a psychiatrist. In the future, more and more such facilities will probably be established.

The main advantages of the treatment of alcoholics in a general hospital are:

(1) The alcoholic usually has other medical problems which can be given more complete treatment.
(2) The alcoholic can be treated closer to home where he can be visited by his family and friends.
(3) The alcoholic is more likely to know the doctor and his staff personally, and therefore can more easily establish a good relationship with them.
(4) The general hospital, with its outpatient clinic and field staff, can follow up on the treatment of the alcoholic after he leaves the hospital.

Mental Hospital

Admission to a mental hospital may be through direct and volunary request by a patient, by referral from a doctor or by legal commitment by a court or judge.

Many of the mental hospitals in this country are too crowded to accept patients who have an alcohol problem only. On the other hand, there are some mental hospitals which have a special program for the treatment of alcoholism and many persons have been helped by them.

The most common methods used to treat alcoholism in mental hospitals are:

(1) group counseling or "group therapy"
(2) drugs, such as sedatives and tranquilizers
(3) occupational therapy and training
(4) health education
(5) Antabuse.

The greatest advantages of mental hospitals in the treatment of alcoholism are:

(1) The staff has a long experience with alcoholic patients and greater knowledge of alcoholism problems than staffs of most general hospitals.
(2) The mental hospital may provide a better "atmosphere" for treatment, since the patient is removed from his friends and many of the home problems which may have helped cause his drinking problems.
(3) Through psychotheraphy the alcoholic can learn more about himself in relation to his alcohol problem.

Specialized Hospitals

In recent years specialized hospitals for the treatment of alcoholism have been established in a few States. For the most part, such hospitals are privately owned and operated, with a well-qualified staff and a well-organized program for alcoholics. The methods of treatment used are basically the same as those listed under "mental hospitals" but patients usually are given more personal attention. One disadvantage is that some Indian patients might find it difficult to fit into such a program, since these hospitals are usually established for alcoholics from a very different background or way of life.

Counseling Programs

Group Counseling

This is a method of treatment in which a psychiatrist or other trained person meets regularly with a group of alcoholics or problem drinkers. The leader encourages discussion among the group concerning alcohol and its effects on the individual, family and community. The alcoholics talk out their problems with each other. Those who have been successful in giving up the habit describe their experiences for the benefit of the others, while those who still need support are given encouragement by the other members of the group. Often group counseling is successful in giving a patient with an alcohol problem a new outlook and new courage. Regular meetings with full participation are necessary for this method to be successful.

Individual Counseling

A personal discussion between a patient and a trained worker such as a doctor, nurse, social worker or minister may be called individual counseling. In this type of treatment the patient knows he can discuss his alcohol problem freely with someone who cares and who wants to help and that the counselor will never laugh at him, or use this information against him in any way.

Counseling often helps the alcoholic to understand himself and his problem better than he could by himself. He has the chance to describe his feelings about alcohol, about himself, his family, and his job. Individual counseling, like group counseling, usually requires regular meetings, since it depends on the counselor and the patient getting to know each other farily well.

Community Alcoholism Councils

A community alcoholism council is a group of people in a community who are interested in joining together to deal with the problems of alcoholism. The council may be independent or it may be set up by the Tribal Council. It often consists of ordinary responsible citzens, especially recovered alcoholics, as well as some of the trained workers in the community.

An alcoholism council may have many functions, depending on the interests of its members and the type of problem in the community. They may coordinate existing services, hold educational meetings or collect information on alcoholism from the hospital, clinic, police, welfare office and other sources, plan what is needed to improve services for alcholics and even seek grants for an alcoholism program from Federal or State agencies. Perhaps the most important job for alcoholism councils, however, is to bring together people who understand the community and who want to do something about alcoholism. Such a council, by its hard work, may be effective in changing the attitude of the whole community toward this problem.